# WALTER REED INFORMED CONSENT

522-113 NSN 7540-00-634-4165

| MEDICAL RECORD | REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES |
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A. IDENTIFICATION

1. OPERATION OR PROCEDURE ☐ ANESTHESIA ☐ SEDATION ☐ TRANSFUSION (see back of form) ☐ Check All Indicated Boxes

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____
*(Description of operation or procedure in layman's language)*

_____

_____

which is to be performed by or under the direction of Dr. _____

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: _____
*(If "none", so state)*

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

*(Cross out any parts above which are not appropriate)*

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to Anesthesia/Sedation/Transfusion, as noted above, and to recuperation, possible results of non-treatment, and significant alternative therapies.

_____
*(Signature of Counseling Physician/Dentist)*
*Licensed Independent Provider*

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed. I am aware of potential problems related to Anesthesia/Sedation/Transfusion, as noted above, and to recuperation, possible results of non-treatment, and significant alternative therapies.

| _____ | _____ | _____ |
|---|---|---|
| *(Signature of Witness, excluding members of operating team)* | *(Signature of Patient)* | *(Date and Time)* |

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed. I am aware of potential problems related to Anesthesia/Sedation/Transfusion, as noted above, and to recuperation, possible results of non-treatment, and significant alternative therapies.

| _____ | _____ | _____ |
|---|---|---|
| *(Signature of Witness, excluding members of operating team)* | *(Signature of Sponsor/Legal Guardian)* | *(Date and Time)* |

| PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)* | REGISTER NO. | WARD NO. |
|---|---|---|
| | | |

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Medical Record

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STANDARD FORM 522 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

During the course of your treatment at Walter Reed Army Medical Center, you may receive a transfusion of one or more blood products. Your physician will outline the expected benefits of such a procedure to you. WRAMC (and the entire military blood banking community) complies with all 6f the stringent regulatory standards designed to make our blood as safe as possible. Despite this, there are several well-established risks of transfusion. These risks are outlined below.

| | |
|---|---|
| Hepatitis B virus | Less than 1 in 100,000 units transfused |
| Hepatitis C virus | Less than 1 in 1 million units transfused |
| HTLV (a white cell virus | 1 in 641,000 units transfused |
| HIV virus (AIDS virus) | Less than 1 in 1 million units transfused |

1. **Transmission of Infectious Diseases** Each potential blood donor is screened very carefully before donation to ensure maximum safety of the blood that he is donating, and each unit of blood is tested for infectious agents prior to transfusion. We constantly strive to improve our ability to detect infectious agents. However, transmission of infectious agents is still a possibility. The table below outlines the currently accepted estimates of risk of infectious agent transmission per unit transfused.

2. **Fever**
Mild increases in temperature, accompanied by chills, are not uncommon following transfusion. Your physician may give you Tylenol before your transfusion to prevent this. It is very important that you report any chills you have during your transfusion to your nurse or physician, because in very rare instances, fever may indicate a more significant problem.

3. **Allergic reactions**
Occasionally, your body may respond to transfusion with an allergic reaction. These reactions are generally very mild, and include itching and rash. Your physician may give you Benadryl before your transfusion to prevent this. Very rarely, more serious allergic reactions may occur and cause breathing problems, throat swelling, or low blood pressure. Again, please report any problems you have during your transfusion, no matter how small they may seem, to your nurse or physician.

4. **Hemolysis**
Very rarely, the blood that is transfused to you can be destroyed by your body, leading to potentially harmful effects. Your physician, the nursing staff, and the WRAMC Blood Bank go to great lengths to ensure that this doesn't occur. For your part, you may again help by reporting anything unusual you feel during your transfusion to your nurse and/or physician.

5. **Complications of Massive Transfusion**
If you require a very large amount of blood in a very short time frame, metabolic problems such as electrolyte imbalance or body temperature changes may occur. In, addition, your normal clotting factors may be diluted. Your physician can give you more information regarding the management of these potential problems.

The above should introduce the major risks of transfusion. You should be aware that for some patients, there are alternatives to transfusion of banked blood. These alternatives include such things as preoperative donation of your own blood for use during or after surgery, intraoperative salvage of your blood, and administration of certain drugs to boost your own level of blood cells. Your physician can supply you with additional details about some of these alternatives.

The Blood Bank is always available to help answer any other questions that you may have about blood transfusion. Feel free to call us at (202) 782-6989 for additional information.